Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-000833
STATE FILE NUMBER

FILED FEB 2 1959 Registration District No. 115-116 Primary Registration District No. 4187 Registrar's No. 30

1. PLACE OF DEATH a. COUNTY FRANKLIN	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY FRANKLIN
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) UNION — Inside Limits Yes [X] No [ ]	c. CITY OR TOWN UNION — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) AT HOME — Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 707 W. SPRINGFIELD — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print)	First: RUTH	Middle: E.	Last: MURRAY	4. DATE OF DEATH Month: JAN. Day: 24, Year: 1959
5. SEX: FEMALE	6. COLOR OR RACE: WHITE	7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	8. DATE OF BIRTH: JAN. 29, 1914	9. AGE (In years last birthday): 44 — IF UNDER 1 YEAR: Months 11 Days 25 — IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY: HOUSEWIFE	11. BIRTHPLACE (City and state or country): SULLIVAN, MO.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME: STEVEN SULLIVAN	13b. MOTHER'S MAIDEN NAME: SUSIE MITCHELL	14. NAME OF HUSBAND OR WIFE: WALTER MURRAY UNION		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT: WALTER MURRAY Address: UNION, MO.		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of breast with metastases — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 17Cx

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 1955, to 1.24.59 and last saw her alive on 1.24.59
Death occurred at 10.P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): F. M. Denny M.D.	22b. ADDRESS: Union Mo	22c. DATE SIGNED: 1.26.59

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: JAN. 27, 1959	23c. NAME OF CEMETERY OR CREMATORY: UNION CEMETERY	23d. LOCATION (City, town, or county) (State): UNION, MO.
24. FUNERAL DIRECTOR ADDRESS: OLTMANN FUNERAL HOME UNION, MO.	25. DATE RECD. BY LOCAL REG.: 1/27/59	26. REGISTRAR'S SIGNATURE: F. L. Hudmann [signature]	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

APR 24 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. ..... working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed Ralph Ottmann

Licensed Embalmer No. 4808

P. O. Address Union, Me

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.